DROP OFF PATIENT INFORMATION

FIDALGO ANIMAL MEDICAL CENTER

Client Name: _____

Patient Name**:** _____

Date of visit: _____

REASON FOR VISIT: _____

MEDICATIONS/FLEA CONTROL: _____ LAST DOSE: _____

*APPETITE: Good __ Fair __ Poor __ *VOMITING: Yes __ No __

If yes, when did it start, and how frequently is it occurring? _____

WATER INTAKE: Normal __ Increased __ Decreased __

ELIMINATION:

Bowel movements: Normal __ Diarrhea __ Straining __ Constipation __ Blood __

Urination: Normal __ Abnormal (describe)_____

PLEASE DESCRIBE ANY OTHER SYMPTOMS THAT ARE OF CONCERN:

_____

_____

_____

*Your pet will receive an examination while in our hospital. Kennel use fees will apply (1/2 day: $18.80).

*Please **choose and initial one option below** regarding how you wish us to proceed if any problems are found with your pet, or if any develop while your pet is in our care:

____ Any tests/treatments deemed necessary for my pet.

____ Any tests/treatments deemed necessary for my pet, up to $150.00 or (**Specify dollar amount**) _____.

____ Do not perform any tests/treatments after the exam until you have spoken with me.

TIME AVAILABLE FOR PHONE CONSULTATION WITH DOCTOR: _____

***If sedation/anesthesia is required initial below: I hereby authorize Fidalgo Animal Medical Center to perform anesthesia, treatment and/or surgical procedures as deemed necessary for my pet. I understand the nature of the procedure and that there may be risk involved. No guarantee has been made as to the result or cure. _____ .**

Owner Signature: _____ PHONE #: _____